SUMMIT COUNTY DOMESTIC RELATIONS COURT
EXPLANATION OF HEALTH CARE BILLS

Instructions: You must bring copies of health care bills, explanation of benefits forms, and proof of payment to the hearing.

Case No. _____

Name of Child: _____

Date of Treatment	Name of Service Provider (e.g., Doctor, Dentist, Therapist, Hospital) and Services Provided	Total Bill	Date Bill Sent to Other Party	Amount Insurance Paid	Amount You Paid	Amount Paid by Other Party	Amount of Unpaid Bill	Amount Due from Other Party

_____ **Date** _____ **Total Amount of Claim:** _____

Your Name / Signature

Summit County Court of Common Pleas, Domestic Relations Division
Domestic Relations Form 29
Explanation of Health Care Bills
Amended Sep. 21, 2020
Amended from Supreme Court of Ohio Uniform Domestic Relations Form 29